

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155241		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/15/2014	
NAME OF PROVIDER OR SUPPLIER FOREST CREEK VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 525 E THOMPSON RD INDIANAPOLIS, IN 46227			
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaints IN00157252 and IN00157308.</p> <p>Survey dates: October 6, 7, 8, 9, 10, 13, 14, and 15, 2014</p> <p>Facility number: 000145 Provider number: 155241 AIM number: 100275110</p> <p>Survey team: Dorothy Plummer, RN-TC Marsha Smith, RN (October 6, 7, 8, 13, 14, and 15, 2014) Karyn Homan, RN (October 6, 7, 8, and 9, 2014) Patsy Allen, SW (October 7, 8, 9, 10, 13, 14, and 15, 2014)</p> <p>Census bed type: SNF: 11 SNF/NF: 104 Total: 115</p> <p>Census payor type: Medicare: 17 Medicaid: 77 Other: 21</p>			F000000	Forest Creek Village respectfully requests a face to face IDR for scope and severity of F223, F225, and F226		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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F000279 SS=D	<p>Total: 115</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on October 21, 2014; by Kimberly Perigo, RN.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10,</p>				

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	<p>including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to ensure care plans were developed for a resident with diabetes (Resident #130) and a resident with a feeding tube (Resident #38) for 2 of 28 residents who met the criteria for review of care plans.</p> <p>Findings include:</p> <p>1. The clinical record of Resident #130 was reviewed on 10/8/14 at 2:49 p.m. Diagnoses for the resident included, but were not limited to diabetes mellitus and dementia. Diabetes mellitus is a disease in which the body is unable to control the amount of sugar in the blood, because it does not have enough insulin.</p> <p>Resident #130 had a physician's order dated 8/8/14, for Lantus insulin to be injected daily at bedtime. He was also to receive fingerstick blood glucose tests 2 times per day, (ordered 9/5/14) and he was to receive a sliding scale dose of Novolog insulin 2 times per day, based on the results of his fingerstick glucose tests (ordered 9/5/14).</p> <p>No care plan for diabetes, including the administration of the fingerstick blood glucose tests and administration of</p>		F000279	<p>F279 DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ·Resident #130 has a care plan for diabetes ·Resident #38 has a care plan for a feeding tube How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? ·All residents who have the diagnosis of diabetes, or have a feeding tube that reside in this facility have the potential to be affected by the alleged deficient practice ·The MDS Coordinator/designee reviewed all clinical records to identify residents who have the diagnosis of diabetes or have a feeding tube and care plan will be developed ·The Interdisciplinary Team will</p>		11/03/2014	

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	<p>insulin, was found in Resident #130's record.</p> <p>On 10/14/14 at 10:40 a.m., the Minimum Data Set (MDS) Coordinator indicated a diabetic careplan had not been initiated for Resident #130.</p> <p>2. The clinical record of Resident #38 was reviewed on 10/15/14 at 9:41 a.m. Diagnoses for the resident included, but were not limited to, gastroesophageal reflux disease, bipolar disorder, and schizoaffective disorder.</p> <p>Resident #38 had a gastrostomy (enteral) tube through which she received all of her medications. A gastrostomy tube is a tube surgically inserted through the skin into the stomach, through which feedings and medications can be given.</p> <p>A careplan for care of the gastrostomy tube was not found in the Resident #38's record. On 10/15/14 at 10:00 a.m., the MDS coordinator indicated the resident should have a careplan for the gastrostomy tube. A new care plan for care of the gastrostomy tube was provided by the MDS coordinator on 10/15/14 at 10:27 a.m.</p> <p>3.1-35(a)</p>		<p>review all physician's orders, facility activity report, new admissions and re-admissions, and residents with significant changes in the clinical meeting utilizing the IDT admission/readmission review form, and IDT Quarterly Resident Review Form Tool to identify residents who have the diagnosis of diabetes, or have a feeding tube to ensure appropriate care plan is developed daily Monday-Friday and Weekend Supervisor/designee will review on Saturday and Sunday</p> <p>· Licensed nurses have been in-serviced by 11/03/14 by the Director of Nursing Services or designee on admission and temporary care plans</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>· All residents who have the diagnosis of diabetes, or have a feeding tube that reside in this facility have the potential to be affected by the alleged deficient practice</p> <p>· The MDS Coordinator/designee reviewed all clinical records to identify residents who have the diagnosis of diabetes or have a feeding tube and care plan will be developed</p>				

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F000282	483.20(k)(3)(ii)			<p>·The Interdisciplinary Team will review all physician's orders, facility activity report, new admissions and re-admissions, and residents with significant changes in the clinical meeting utilizing the IDT admission/readmission review form, and IDT Quarterly Resident Review Form Tool to identify residents who have the diagnosis of diabetes, or have a feeding tube to ensure appropriate care plan is developed daily Monday-Friday and Weekend Supervisor/designee will review on Saturday and Sunday</p> <p>·Licensed nurses have been in-serviced by 11/03/14 by the Director of Nursing Services or designee on admission and temporary care plans</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>·Care Plan Updating CQI tool will be utilized weekly x 4, monthly x 6, and quarterly thereafter for one year. Data will be submitted to the CQI committee for follow up. If 95% threshold is not achieved, an action plan will be developed.</p>			

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SS=E	<p>SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to ensure plans of care were followed for 2 residents receiving sliding scale insulin (Resident #30 and Resident #130) and 2 residents receiving showers (Resident #6 and Resident #41) for 4 of 28 residents reviewed for care plans being followed.</p> <p>Findings include:</p> <p>1. The clinical record of Resident #130 was reviewed on 10/8/14 at 2:49 p.m. Diagnoses for the resident included, but were not limited to diabetes mellitus and dementia. Diabetes mellitus is a disease in which the body is unable to control the amount of sugar in the blood because it does not have enough insulin.</p> <p>A physician's order, dated 9/5/14, indicated Resident #130 was to receive fingerstick blood sugar tests 4 times per day for 1 week, then 2 times per day thereafter. The order indicated he was to receive Novolog sliding scale insulin (a medication injected into the body to help lower blood sugar) according to the</p>	F000282	<p>F 282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified person in accordance with each resident's written plan of care.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Resident #30 will have blood glucose testing, and sliding scale insulin administered per physician's order ·Resident #130 will have blood glucose testing, sliding scale insulin administered, and physician notification per physician's order ·Resident #6 is receiving showers and shaving per resident preference ·Resident #41 is receiving showers per shower schedule <p>How will you identify other residents having the potential to be affected by the same</p>		11/03/2014		

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	<p>following sliding scale:</p> <p>Blood sugar (BS) results: 1-150 = 0 units of Novolog insulin BS 151-200 = 2 units insulin BS 201-250 = 4 units insulin BS 251-300 = 6 units insulin BS 301-350 = 8 units insulin BS 351-400 = 10 units insulin BS 401-450 = 12 units insulin Call physician if BS less than 60 or over 350.</p> <p>A Diabetic Monitoring Flowsheet for September, 2014 indicated the following:</p> <p>On 9/12/14 at 11:00 a.m. Resident #130's blood sugar was 353. There was no indication in the record the physician was notified, according to orders.</p> <p>9/18/14 at 6:00 a.m. BS = 223. 2 units of insulin given. Should have received 4 units.</p> <p>9/19/14 at 4:00 p.m. BS = 180. No insulin was indicated as given. Should have received 2 units.</p> <p>9/20/14 at 4:00 p.m. BS = 164. No insulin was indicated as given. Should have received 2 units.</p>		<p>deficient practice and what correctiveaction will be taken?</p> <ul style="list-style-type: none"> ·All residents who have blood glucose testing, receive sliding scale insulin, receive assistance with bathing and shaving have the potential to be affected by the alleged deficient practice ·All resident that require assistance with bathing or shaving will be interviewed by Customer Care Reps on bathing and shaving preferences and care plan will be updated ·Licensed nurses have been in-serviced by Director of Nursing Services or designee by 11/03/14 on blood glucose monitoring, medication administration including administration of sliding scale insulin per physician's orders and physician notification of blood sugars outside of the call parameters ·Licensed Nurses will have another Licensed Nurse verify that the correct dose of sliding scale insulin is drawn up before administration and cosign the Blood Glucose Monitoring Tool ·Licensed Nurses and Certified Nurse's Aides have been in-serviced on bathing and shaving per resident preference, shower sheets, and bathing documentation in Point of Care by the Director of Nursing Services/designee by 11/3/14 				

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	<p>2. The clinical record review completed 10/14/14 at 11:43 a.m., indicated Resident #30 had diagnoses including, but not limited to, diabetes.</p> <p>The recapitulation of physician's orders for 10/1/14 - 10/31/14, included an order with a start date of 8/27/14, for the resident to have blood glucose testing and Humalog (a short acting type of insulin) administered on a sliding scale dosage 3 times a day.</p> <p>A written plan of care dated 8/29/14, indicated the resident was at risk for adverse effects of hyperglycemia (high blood sugar) or hypoglycemia (low blood sugar) related to the diagnosis of diabetes. Interventions included, but were not limited to, monitor blood sugars as ordered.</p> <p>A review of the Capillary Blood Glucose Monitoring Tool for September 2014, lacked documentation of glucose testing and sliding scale insulin administration on 9/21/14 at 11:00 a.m., on 9/29/14 at 6:00 a.m., and 9/30/14 at 6:00 a.m.</p> <p>During an interview with Unit Manager (UM) #6 on 10/14/14 3:30 p.m., UM #6 indicated the staff records the blood sugars on the flowsheet when completed.</p>		<p>·Blood Glucose Monitoring Tool audits will be completed daily and reviewed by Director of Nursing Service/ designee to ensure that blood glucose monitoring, sliding scale insulin, physician notification are done per physician orders daily Monday-Friday and Weekend Supervisor/designee on Saturday and Sunday</p> <p>·The Interdisciplinary Team will review all physicians orders related to blood glucose in clinical meeting to ensure that services are provided according to physician's orders.</p> <p>·The Interdisciplinary Team will review in clinical meeting all shower sheets against the shower schedule Monday-Friday and weekend supervisor/designee on Saturday and Sunday to ensure showers were offered and appropriate documentation occurred</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>·All residents who have blood glucose testing, receive sliding scale insulin, receive assistance with bathing and shaving have the</p>				

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	<p>During an interview with the Director of Nursing Services (DNS) and the Corporate Nurse Consultant on 10/15/14 at 3:30 p.m., the DNS indicated blood glucose monitoring and the administration of sliding scale insulin should be recorded on the Capillary Blood Glucose Monitoring Tool.</p> <p>3. During a Stage 1 interview on 10/7/14 at 9:59 a.m., Resident #6 was observed with unshaven facial hair. Resident #6 indicated shaving was provided on showers days, he received 1 shower a week, and the last shower was completed last week. The resident expressed a preference for more frequent shaving and bathing.</p> <p>The clinical record review on 10/8/14 at 2:36 p.m., indicated Resident #6 had diagnoses including, but not limited to, cerebral vascular accident (CVA/stroke) with right sided hemiparesis (weakness of the entire right side).</p> <p>An annual Minimum Data Set assessment (MDS) completed 7/22/14, assessed Resident #6 with a Brief Interview for Mental Status (BIMS) of 10 out of 15, indicating moderate cognitive impairment. The resident was assessed as requiring extensive assistance of 2 plus staff members for bed mobility, transfers,</p>			<p>potential to be affected by the alleged deficient practice</p> <ul style="list-style-type: none"> ·All resident that require assistance with bathing or shaving will be interviewed by Customer Care Rep on bathing and shaving preferences and care plan will be updated ·Licensed nurses have been in-serviced by Director of Nursing Services or designee by 11/03/14 on blood glucose monitoring, medication administration including administration of sliding scale insulin per physician's orders and physician notification of blood sugars outside of the call parameters ·Licensed Nurses will have another Licensed Nurse verify that the correct dose of sliding scale insulin is drawn up before administration and cosign the Blood Glucose Monitoring Tool ·Licensed Nurses and Certified Nurse's Aides have been in-serviced on bathing and shaving per resident preference, shower sheets, and bathing documentation in Point of Care by the Director of Nursing Services/designee by 11/3/14 ·Blood Glucose Monitoring Tool audits will be completed daily and reviewed by Director of Nursing Service/ designee to ensure that blood glucose monitoring, sliding 			

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	<p>toileting, and personal hygiene. No behaviors, including rejection of care, were coded for the resident.</p> <p>A written plan of care for Resident #6 dated 9/26/2012, indicated the resident had a self care deficit related to the inability to independently perform ADL's with the diagnosis of CVA and right sided hemiparesis. Interventions included, but were not limited to, the resident would be provided a shower 2 times a week and a partial bath in between the showers. The plan of care did not include a shaving preference.</p> <p>During an interview with Unit Manager (UM) #3 on 10/8/14 at 11:30 a.m., the UM #3 provided shower sheets for Resident #6 for September and October 2014, and indicated the staff also documented the provision of care in the computer system utilized by the facility. UM #3 indicated shaving was provided on shower days, and if a resident requested more frequent shaving then the profile for the resident was updated to reflect the request. UM #3 indicated the resident profile was utilized as an assignment sheet for the certified nursing assistants (CNAs). Reviewed resident profile with UM #3 and no shaving preference was indicated on the profile.</p>			<p>scale insulin, physician notification are done per physician orders daily Monday-Friday and Weekend Supervisor/designee on Saturday and Sunday</p> <p>·The Interdisciplinary Team will review all physicians orders related to blood glucose in clinical meeting to ensure that services are provided according to physician's orders.</p> <p>·The Interdisciplinary Team will review in clinical meeting all shower sheets against the shower schedule Monday-Friday and weekend supervisor/designee on Saturday and Sunday to ensure showers were offered and appropriate documentation occurred</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>·Blood Glucose Testing and Accommodation of Needs CQI tool will be utilized weekly x 4, monthly x 6, and quarterly thereafter for one year. Data will be submitted to the CQI committee for follow up. If 95% threshold is not achieved, an action plan will be developed.</p>			

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	<p>A review of the shower sheets indicated the resident received a shower 9/23, 9/30, and 10/7/14.</p> <p>On 10/8/14 at 2:49 p.m., the Director of Nursing Services (DNS) provided a copy of the shower schedule and indicated the schedule was the current schedule utilized on the East Unit where Resident #6 resided. The shower schedule indicated Resident #6 should have received showers on Tuesdays and Fridays during the evening shifts.</p> <p>On 10/9/14 at 11:20 a.m., the MDS Coordinator provided a report generated from the computer system titled, "Point of Care History" which included documentation of showers and partial baths for 9/1/14 through 10/9/14. The report lacked documentation of the provision of a shower from 9/23/14 through 10/9/14 for Resident #30.</p> <p>4. During a Stage 1 interview with Resident #41 on 10/6/14 at 3:28 p.m., the resident was observed to have a thick yellow matting in both eyes and an orange colored substance around the mouth and onto the chin in white facial hair.</p> <p>The clinical record review completed on 10/8/14 at 2:47 p.m., indicated Resident</p>						

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	<p>#41 had diagnoses including, but not limited to, right cerebral vascular accident (CVA/stroke) with left sided hemiparesis (weakness of the entire left side).</p> <p>A quarterly Minimum Data Set assessment (MDS) completed 9/27/14, assessed Resident #41 as having a Brief Interview for Mental Status (BIMS) of 5 out of 15, indicating moderate cognitive impairment. The resident was assessed as requiring extensive assistance of 2 plus staff member for bed mobility, transfers, dressing, toileting, and personal hygiene. The assessment indicated the resident exhibited behavior not directed toward others and rejection of care 1-3 days of the assessment period.</p> <p>A written plan of care for Resident #41 completed 10/14/2011, indicated the resident had a self care deficit related to the inability to independently perform activities of daily living (ADL's) with a diagnosis of CVA with left sided hemiparesis. Interventions included, but were not limited to, dependent of 2 staff with care as needed, provide oral care at least 2 times per day, and provide shower 2 times per week with partial bath in between and prefers Wednesday/Saturday.</p>						

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NAME OF PROVIDER OR SUPPLIER FOREST CREEK VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 525 E THOMPSON RD INDIANAPOLIS, IN 46227			
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	<p>During an interview with Unit Manager (UM) #3 on 10/8/14 at 11:30 a.m., the UM #3 provided shower sheets for Resident #41 for September and October 2014, and indicated the staff also documented the provision of care in the computer system utilized by the facility.</p> <p>On 10/8/14 at 2:49 p.m., the Director of Nursing Services (DNS) provided a copy of the shower schedule and indicated the schedule was the current schedule utilized on the East Unit, where Resident #41 resided. The shower schedule indicated Resident #41 should have received showers on Tuesdays and Fridays during the evening shifts.</p> <p>During an interview 10/9/14 at 10:30 a.m., UM #3 indicated the resident frequently refused care including removing substances from the facial hair and showers and staff had to make multiple attempts to complete care.</p> <p>A review of the shower sheets indicated the resident received a showers 9/5, 9/12, 9/16, and 9/23/14 and a bed bath 9/9, 9/25, 10/3, and 10/7/14 due to resident refusing a shower. No documentation was provided for a shower or bed bath for the dates 9/2, 9/19 or 9/30/14.</p> <p>On 10/9/14 at 11:20 a.m., the MDS</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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F000312	<p>Coordinator provided a report generated from the computer system titled, "Point of Care History" which included documentation of showers and partial baths for 9/1/14 through 10/9/14. The report lacked documentation of the provision of a shower from 9/17/14 through 10/9/14, for Resident #41.</p> <p>During an interview with the DNS on 10/10/14 at 4:30 p.m., the DNS indicated the shower sheets were an internal tool used by the staff to document the provision of showers and the staff should be documenting in the computer system when a shower was provided.</p> <p>On 10/8/14 at 2:38 p.m., the Director of Nursing Services (DNS) provided an undated policy on Showers and Oral Care and indicated it was the current policy used by the facility. The policy indicated, "...We will offer a shower to each resident twice weekly or per resident preference...."</p> <p>3.1-35(g)(2)</p>						

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SS=D	<p>ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, interview, and record review, the facility failed to provide the necessary services to maintain good grooming and personal hygiene for 2 of 3 residents reviewed for Activities of Daily Living (ADL's). (Resident #30 and Resident #41)</p> <p>Findings include:</p> <p>1. During a Stage 1 interview on 10/7/14 at 9:59 a.m., Resident #30 was observed with unshaven facial hair. Resident #30 indicated shaving was provided on showers days, he received 1 shower a week, and the last shower was completed last week. The resident expressed a preference for more frequent shaving and bathing.</p> <p>The clinical record review on 10/8/14 at 2:36 p.m., indicated Resident #30 had diagnoses including, but not limited to, cerebral vascular accident (CVA/stroke) with right sided hemiparesis (weakness of the entire right side).</p> <p>An annual Minimum Data Set assessment</p>			F000312	<p>F312 ADL care provided for dependent residents</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Resident #30 was incorrectly identified in 2567. Should be Resident #6. Resident #6 is receiving showers and shaving per resident preference ·Resident #41 is receiving showers per shower schedule <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents who receive 		11/03/2014

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	<p>(MDS) completed 7/22/14, assessed Resident #30 with a Brief Interview for Mental Status (BIMS) of 10 out of 15, indicating moderate cognitive impairment. The resident was assessed as requiring extensive assistance of 2 plus staff members for bed mobility, transfers, toileting, and personal hygiene. No behaviors, including rejection of care, were coded for the resident.</p> <p>A written plan of care for Resident #30 dated 9/26/2012, indicated the resident had a self care deficit related to the inability to independently perform ADL's with the diagnosis of CVA and right sided hemiparesis. Interventions included, but were not limited to, the resident would be provided a shower 2 times a week and a partial bath in between the showers. The plan of care did not include a shaving preference.</p> <p>During an interview with Unit Manager (UM) #3 on 10/8/14 at 11:30 a.m., the UM #3 provided shower sheets for Resident #30 for September and October 2014, and indicated the staff also documented the provision of care in the computer system utilized by the facility. UM #3 indicated shaving was provided on shower days, and if a resident requested more frequent shaving then the profile for the resident was updated to</p>				<p>assistance with bathing and shaving have the potential to be affected by the alleged deficient practice</p> <p>·All resident that require assistance with bathing or shaving will be interviewed by Customer Care Reps on bathing and shaving preferences and care plan will be updated</p> <p>·Licensed Nurses and Certified Nurse's Aides have been in-serviced on bathing and shaving per resident preference, shower sheets, and bathing documentation in Point of Care by the Director of Nursing Services/designee by 11/3/14</p> <p>·Director of Nursing Service/designee will review shower sheets against the shower schedule Monday-Friday and weekend supervisor/designee on Saturday and Sunday to ensure showers were offered and appropriate documentation occurred per resident preference</p> <p>·Licensed Nurses will conduct rounds on all shifts to ensure residents well groomed and clean</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>·All residents and new residents</p>		

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	<p>reflect the request. UM #3 indicated the resident profile was utilized as an assignment sheet for the certified nursing assistants (CNAs). Reviewed resident profile with UM #3 and no shaving preference was indicated on the profile.</p> <p>A review of the shower sheets indicated the resident received a shower 9/23, 9/30, and 10/7/14.</p> <p>On 10/8/14 at 2:49 p.m., the Director of Nursing Services (DNS) provided a copy of the shower schedule and indicated the schedule was the current schedule utilized on the East Unit where Resident #30 resided. The shower schedule indicated Resident #30 should have received showers on Tuesdays and Fridays during the evening shifts.</p> <p>On 10/9/14 at 11:20 a.m., the MDS Coordinator provided a report generated from the computer system titled, "Point of Care History" which included documentation of showers and partial baths for 9/1/14 through 10/9/14. The report lacked documentation of the provision of a shower from 9/23/14 through 10/9/14, for Resident #30.</p> <p>2. During a Stage 1 interview with Resident #41 on 10/6/14 at 3:28 p.m., the resident was observed to have a thick</p>		<p>that require assistance with bathing or shaving will be interviewed by Customer Care Rep on bathing and shaving preferences and care plan will be updated</p> <p>·Licensed Nurses and Certified Nurse's Aides have been in-serviced on bathing and shaving per resident preference, shower sheets, and bathing documentation in Point of Care by the Director of Nursing Services/designee by 11/3/14</p> <p>·Director of Nursing Service/designee will review shower sheets against the shower schedule Monday-Friday and weekends supervisor/designee on Saturday and Sunday to ensure showers were offered and appropriate documentation occurred per resident preference</p> <p>·Licensed Nurses will conduct rounds on all shifts to ensure residents well groomed and clean</p> <p>How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>·Accommodation of Needs CQI tool will be utilized weekly x 4, monthly x 6, and quarterly thereafter for one year. Data will be submitted to the CQI committee for follow up. If 95% threshold is not achieved, an</p>				

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	<p>yellow matting in both eyes and an orange colored substance around the mouth and onto the chin in white facial hair.</p> <p>The clinical record review completed on 10/8/14 at 2:47 p.m., indicated Resident #41 had diagnoses including, but not limited to, right cerebral vascular accident (CVA/stroke) with left sided hemiparesis (weakness of the entire left side).</p> <p>A quarterly Minimum Data Set assessment (MDS) completed 9/27/14, assessed Resident #41 as having a Brief Interview for Mental Status (BIMS) of 5 out of 15 indicating moderate cognitive impairment. The resident was assessed as requiring extensive assistance of 2 plus staff member for bed mobility, transfers, dressing, toileting, and personal hygiene. The assessment indicated the resident exhibited behavior not directed toward others and rejection of care 1-3 days of the assessment period.</p> <p>A written plan of care for Resident #41 completed 10/14/2011, indicated the resident had a self care deficit related to the inability to independently perform activities of daily living (ADL's) with a diagnosis of CVA with left sided hemiparesis. Interventions included, but</p>			action plan will be developed.			

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	<p>were not limited to, dependent of 2 staff with care as needed, provide oral care at least 2 times per day, and provide shower 2 times per week with partial bath in between and prefers Wednesday/Saturday.</p> <p>During an interview with Unit Manager (UM) #3 on 10/8/14 at 11:30 a.m., the UM #3 provided shower sheets for Resident #41 for September and October 2014, and indicated the staff also documented the provision of care in the computer system utilized by the facility.</p> <p>On 10/8/14 at 2:49 p.m., the Director of Nursing Services (DNS) provided a copy of the shower schedule and indicated the schedule was the current schedule utilized on the East Unit, where Resident #41 resided. The shower schedule indicated Resident #41 should have received showers on Tuesdays and Fridays during the evening shifts.</p> <p>During an interview 10/9/14 at 10:30 a.m., UM #3 indicated the resident frequently refused care including removing substances from the facial hair and showers and staff had to make multiple attempts to complete care.</p> <p>A review of the shower sheets indicated the resident received a showers 9/5, 9/12,</p>						

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	<p>9/16, and 9/23/14 and a bed bath 9/9, 9/25, 10/3, and 10/7/14 due to resident refusing a shower. No documentation was provided for a shower or bed bath for the dates 9/2, 9/19 or 9/30/14.</p> <p>On 10/9/14 at 11:20 a.m., the MDS Coordinator provided a report generated from the computer system titled, "Point of Care History" which included documentation of showers and partial baths for 9/1/14 through 10/9/14. The report lacked documentation of the provision of a shower from 9/17/14 through 10/9/14, for Resident #41.</p> <p>During an interview with the DNS on 10/10/14 at 4:30 p.m., the DNS indicated the shower sheets were an internal tool used by the staff to document the provision of showers and the staff should be documenting in the computer system when a shower was provided.</p> <p>On 10/8/14 at 2:38 p.m., the Director of Nursing Services (DNS) provided an undated policy on Showers and Oral Care and indicated it was the current policy used by the facility. The policy indicated, "...We will offer a shower to each resident twice weekly or per resident preference...."</p> <p>3.1-38(a)(3)(D)</p>						

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F000322 SS=D	<p>3.1-38(b)(2)</p> <p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that --</p> <p>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, record review, and interview, the facility failed to ensure medications were administered through an enteral tube according to their policy, for 1 of 1 observation of medications administered through an enteral tube. (Resident #38)</p> <p>Findings include:</p> <p>The clinical record of Resident #38 was reviewed on 10/15/14 at 9:41 a.m. Diagnoses for the resident included, but</p>		F000322	<p>F322 NGTreatment/Services-Restore Eating Skills</p> <p>Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice?</p> <p>·Resident #38 has placement of enteraltube verified prior to administration of medications through enteral tubeaccording to American Senior Community policy</p>		11/03/2014	

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	<p>were not limited to bipolar disorder and schizoaffective disorder.</p> <p>A recapitulated physician's order for October, 2014, with an original order date of 7/7/14, indicated Resident #38 was to receive all of her medications through her gastrostomy tube (GT), a tube surgically inserted through the skin into the stomach. A GT is also called an enteral tube.</p> <p>On 10/8/14 at 12:10 p.m., Licensed Practical Nurse (LPN) #7 was observed preparing to give a medication to Resident #38 through her enteral tube. Unit Manager #6 was also in the room observing.</p> <p>LPN #7 washed her hands, and used a syringe to check for residual. There was no residual observed. LPN #7 then appeared to be starting to put Resident #38's medication through her enteral tube. Unit Manager #6 stopped her and asked, "Did you bring your stethoscope with you." LPN #7 answered, "No, I forgot it." Unit Manger #6 left the room, returned with a stethoscope, and handed it to LPN #7. At that time, LPN #7 injected a small amount of air into the enteral tube, while listening to the stomach with the stethoscope. This was done to check correct placement of the</p>		<p>·LPN#7 was in-serviced immediately by the Unit Manager on the EnteralTube-Medication Administration and Enteral Tube Procedure policy.</p> <p>Howwill you identify other residents having the potential to be affected by thesame deficient practice and what corrective action will be taken?</p> <p>·Allresidents receiving medications via g-tube have the potential to be affected</p> <p>·LicensedNurses have been in-serviced on verifying G-Tube placement prior to medicationadministration by the Director of Nursing Services/designee by 11/3/14</p> <p>·AllLicensed Nurses will complete an observed G-tube skills validation by DNS ordesignee to verify training</p> <p>·Directorof Nursing/Designee will make rounds each shift to ensure placement is verifiedprior to medication administration</p> <p>Whatmeasures will be put into place or what systemic changes you will make toensure that the deficient practice does not recur?</p> <p>·Licensed Nurses have been in-serviced on verifying G-Tube</p>				

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F000329	<p>enteral tube.</p> <p>On 10/15/14 at 1:05 p.m., the Director of Nursing Services provided a policy, dated 9/2012, titled Enteral Tube Procedure, and indicated it was the policy currently used by the facility. The policy indicated, "...B. Enteral Tube - Gastric Content & Patency Procedure...5. Attach a 30-60 cc syringe to feeding tube and aspirate for stomach contents...7. Remove syringe and obtain 20-30 cc [cubic centimeters] of air in syringe. 8. Place stethoscope on stomach area, attach syringe to end of enteral tube, slowly inject 20-30 cc of air into the enteral tube. Listen to detect a whooshing, bubbling or gurgling sound to confirm tube placement and patency..."</p> <p>Geriatric Medication Handbook Med*Pass Eighth Edition indicated, "...Enteral Tube Administration Medication Administration Via Enteral Tubes...Procedures:...6. Prepare medications for administration. 7. Elevate head of bed 30 to 45 degrees. 8. Check for proper tube placement. Check gastric content for residual..."</p> <p>3.1-44(a)(2)</p>		<p>placement prior to medication administration by the Director of Nursing Services/designee by 11/3/14</p> <ul style="list-style-type: none"> All Licensed Nurses and all new nurses hired will complete an observed G-tubeskills validation by DNS or designee to verify training Director of Nursing/Designee will make rounds each shift daily to ensure placement is verified prior to medication administration <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> Enteral Therapy CQI tool will be utilized weekly x4, monthly x 6, and quarterly thereafter for one year. Data will be submitted to the CQI committee for follow up. If 95% threshold is not achieved, an action plan will be developed. 				

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SS=D	<p>DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to ensure blood glucose monitoring and sliding scale insulin administration was completed for 1 of 2 residents reviewed for blood glucose monitoring. (Resident #30)</p> <p>Findings include:</p> <p>The clinical record review completed 10/14/14 at 11:43 a.m., indicated Resident #30 had diagnoses including, but not limited to, diabetes.</p>	F000329	<p>F329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above</p>	11/03/2014			

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	<p>The recapitulation of physician's orders for 10/1/14 - 10/31/14 included an order with a start date of 8/27/14, for the resident to have blood glucose testing and Humalog (a short acting type of insulin) administered on a sliding scale dosage 3 times a day.</p> <p>A written plan of care dated 8/29/14, indicated the resident was at risk for adverse effects of hyperglycemia (high blood sugar) or hypoglycemia (low blood sugar) related to the diagnosis of diabetes. Interventions included, but were not limited to, monitor blood sugars as ordered.</p> <p>A review of the Capillary Blood Glucose Monitoring Tool for September 2014, lacked documentation of glucose testing and sliding scale insulin administration on 9/21/14 at 11:00 a.m., on 9/29/14 at 6:00 a.m., and on 9/30/14 at 6:00 a.m.</p> <p>During an interview with Unit Manager #6 on 10/14/14 3:30 p.m., UM #6 indicated the staff records the blood sugars on the flowsheet when completed.</p> <p>During an interview with the Director of Nursing Services (DNS) and the Corporate Nurse Consultant on 10/15/14 at 3:30 p.m., the DNS indicated blood glucose monitoring and the</p>		<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> Resident #30 will have blood glucose monitoring and sliding scale insulin administered per physician's order <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All residents who have blood glucose testing, receive sliding scale insulin have the potential to be affected by the alleged deficient practice Licensed nurses have been in-serviced by Director of Nursing Services or designee by 11/03/14 on blood glucose monitoring, medication administration including administration of sliding scale insulin per physician's orders Licensed Nurses will have another Licensed Nurse verify that the correct dose of sliding scale insulin is drawn up before administration and co-sign the Blood Glucose Monitoring Tool Blood Glucose Monitoring Tool audits will be completed daily and reviewed by Director of Nursing Service/ designee to ensure that blood glucose monitoring and sliding scale insulin are done per 				

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	administration of sliding scale insulin should be recorded on the Capillary Blood Glucose Monitoring Tool. 3.1-48(a)(3)			<p>physician orders daily Monday-Friday and Weekend Supervisor/designee on Saturday and Sunday</p> <p>·The Interdisciplinary Team will review all physicians orders related to blood glucose in clinical meeting to ensure that services are provided according to physician's orders Monday-Friday and weekend supervisor/designee on Saturday and Sunday</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>·Licensed nurses have been in-serviced by Director of Nursing Services or designee by 11/03/14 on blood glucose monitoring, medication administration including administration of sliding scale insulin per physician's orders</p> <p>·Licensed Nurses will have another Licensed Nurse verify that the correct dose of sliding scale insulin is drawn up before administration and cosign the Blood Glucose Monitoring Tool</p> <p>·Blood Glucose Monitoring Tool audits will be completed daily and reviewed by Director of Nursing Service/ designee to ensure that blood glucose monitoring and</p>			

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F000333 SS=D	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on observation, record review, and interview, the facility failed to ensure a medication was measured properly to ensure correct dosage for 1 of 28 medications observed.</p>		F000333	<p>sliding scale insulin are done per physician orders daily Monday-Friday and Weekend Supervisor/designee on Saturday and Sunday</p> <p>The Interdisciplinary Team will review all physicians orders related to blood glucose in clinical meeting to ensure that services are provided according to physician's orders Monday-Friday and weekend supervisor/designee on Saturday and Sunday</p> <p>Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place? Blood Glucose Monitoring CQI tool will be utilizedweekly x 4, monthly x 6, and quarterly thereafter for one year. Data will be submitted to the CQI committee for follow up. If 95% threshold is notachieved, an action plan will be developed.</p> <p>What corrective action(s) will be accomplishedfor those residents found to have been affected by the deficient</p>		11/03/2014	

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	<p>Findings include:</p> <p>The clinical record of Resident #38 was reviewed on 10/15/14 at 9:41 a.m. Diagnoses for the resident included, but were not limited to bipolar disorder and schizoaffective disorder.</p> <p>A recapitulated physician's order for October, 2014, with an original order date of 7/7/14, indicated Resident #38 was to receive all of her medications through her gastrostomy tube (GT), a tube surgically inserted through the skin into the stomach.</p> <p>A recapitulated physician's order for October, 2014, with an original order date of 7/3/14, indicated Resident #38 was to receive lithium carbonate 60 mg (milligrams) per ml (milliliter) suspension, 2.1 ml's, to equal 125 milligrams, per GT 3 times per day.</p> <p>Lithium is used to prevent or control mania in bipolar disorder. Nursing 2014 Drug Handbook, 34th Edition, indicates, "Adverse Reactions...fatigue, lethargy, coma,... seizures...psychomotor retardation, blackouts...renal [kidney] toxicity...muscle weakness...use with caution in debilitated patients...Overdose S&S [signs and symptoms] diarrhea,</p>		<p>practice?</p> <ul style="list-style-type: none"> ·Resident #38 receives Lithium perphysician's order ·LPN #7 was immediately inserviced byUnit Manager on the Enteral Medication administration including administrationof liquid medications and correct dosage <p>How will you identify other residents havingthe potential to be affected by the same deficient practice and what correctiveaction will be taken?</p> <ul style="list-style-type: none"> ·All residents who receive liquid suspension medications have the potential to be effected by the alleged deficient practice ·Licensed Nurses will be in-serviced on Medication Administration including preparing correct doses of liquid suspensions by 11/3/14 ·Medication Pass skills validation to beconducted on Licensed Nurses by Director of Nursing or designee ·Directorof Nursing or designee will conduct rounds to monitor medication administrationto ensure proper doses of liquid suspension medications are dispensed asprescribed by the physician ·Medication Pass skills validation willbe conducted on Licensed Nurses upon hire 				

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	<p>vomiting, drowsiness, muscular weakness, lack of coordination...blurred vision, confusion...loss of consciousness, seizures, peripheral vascular collapse, coma...Black Box Warning Drug has a narrow therapeutic margin of safety...even slightly high values can be dangerous..."</p> <p>On 10/8/14 at 11:54 a.m., Licensed Practical Nurse (LPN) #7 was observed pouring lithium suspension into a medication cup. The medication cup was observed to be marked in milliliters, starting at 2.5 ml's, 5 ml's, 7.5 ml's, 10 ml's, on up to 30 ml's. There were no markings which indicated 2.1 ml's, the dosage of lithium Resident #130 was prescribed to receive. LPN #7 was observed pouring the lithium into the medication cup, then pouring some of the medication back into the bottle, then repeating the steps several times. LPN #7 indicated at that time, the lithium was usually measured out with a syringe so that the exact dosage could be obtained from the bottle, but the night nurse had dropped the syringe and LPN #7 couldn't find any more syringes to use. LPN #7 indicated pharmacy usually sent a bulk package of syringes, but no one had reordered them.</p> <p>LPN #7 took the lithium she had poured</p>		<p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·Licensed Nurses will be in-serviced on Medication Administration including preparing correct doses of liquid suspensions by 11/3/14 ·Medication Pass skills validation to be conducted on Licensed Nurses by Director of Nursing or designee ·Director of Nursing or designee will conduct rounds to monitor medication administration to ensure proper doses of liquid suspension medications are dispensed as prescribed by the physician ·Medication Pass skills validation will be conducted on Licensed Nurses upon hire <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·Pharmacy Services CQI tool will be utilized weekly x4, monthly x 6, and quarterly thereafter for one year. Data will be submitted to the CQI committee for follow up. If 95% threshold is 				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F000371 SS=E	<p>into the medication cup into the Resident #38's room and prepared to give it to the resident. An observation of the lithium in the medication cup indicated the amount of lithium was somewhere between 2.0 and 2.3 ml's. At that time, Unit Manager #6 entered Resident #38's room. She indicated LPN #7 should "absolutely" be using a syringe to withdraw the accurate dose of 2.1 ml's from the bottle of lithium. Unit Manager #6 left the room and returned with syringes, which were delineated with .1 ml. markings. LPN #7 then returned to the medication room, threw away the lithium in the medication cup, and withdrew p.m of lithium, as ordered with a syringe.</p> <p>On 10/8/14 at 12:21 p.m., Unit Manager #6 indicated syringes should always be used when preparing the lithium for Resident #38. At that time she placed extra syringes with the bottle of the medication.</p> <p>3.1-48(c)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p>				notachieved, an action plan will be developed.		

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	<p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to ensure 114 of 115 residents, who ate food prepared in the kitchen, received food prepared, distributed and served under sanitary conditions.</p> <p>Findings include:</p> <p>1. On 10/6/14 from 12:30 p.m. to 12:45 p.m., food service was observed in the Moving Forward dining room. Dietary Cook #1 was observed preparing each resident's plate from a steam table cart. She washed her hands and donned gloves. Dietary Cook #1 started preparing plates. She opened the bread bag, removed two slices of bread with her gloved hands and placed the bread on a plate. Dietary Cook #1 continued by picking up a scoop with her gloved hand and placed a serving of turkey salad on one slice of bread. She then picked up the other slice of bread with her gloved hand and placed the bread on top of the turkey salad.</p> <p>Dietary Cook #1 then picked up the cheese puff scoop with the her gloved</p>	F000371	<p>F371 FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·All residents will be served according to proper food handling procedures including hand washing and glove use ·All dietary employees will have hair properly restrained <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents have the potential to be affected by the alleged deficient practice ·Dietary staff will be in-serviced on Infection Control, Use of Gloves, Hand Washing, Dietary Personal Hygiene and Food Handling policies by the Registered Dietician or designee by 11/03/2014 		11/03/2014		

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	<p>hand and placed cheese puffs on the plate next to the turkey salad sandwich. She continued to pick up a bowl and the soup scoop and pour soup into the bowl. She placed these plates on the tray in front of her.</p> <p>Dietary Cook #1 then shuffled through the dining slips of paper with the same gloved hands.</p> <p>Dietary Cook #1 then picked up two more slices of bread and placed them on another plate with the same gloved hands. She continued by picking up the turkey scoop and placed a scoop of turkey salad on one of the slices of bread. She used the same gloved hand and moved the turkey salad around on the piece of bread. She then picked up the other slice of bread with her same gloved hand and put it on top of the scoop of turkey salad.</p> <p>Dietary Cook #1 continued preparing plates of food for the residents with the same gloved hands. She was not observed to use any form of utensil to serve the bread through the observation period. Dietary Cook #1 was not observed to remove the original set of gloves and wash her hands, until after 11 (9 residents and 2 family members) plates of food were prepared and served.</p>		<p>·Registered Dietitian or designee will monitor kitchen processes to ensure proper hand washing, glove use, hair restraints, and food handling follows protocol</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>·Dietary staff will be in-serviced on Infection Control, Use of Gloves, Hand Washing, Dietary Personal Hygiene and Food Handling policies by the Registered Dietician or designee by 11/03/2014</p> <p>·Registered Dietitian or designee will monitor kitchen processes during each meal to ensure proper hand washing, glove use, hair restraints, and food handling follows protocol using audit tool</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>·A Kitchen Sanitation/Environmental Review tool will be utilized weekly X 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Continuous Quality Improvement Committee overseen by the</p>				

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	<p>On 10/6/14 at 1:00 p.m., the Dietary Manager indicated Dietary Cook #1 should have used a different utensil for each food item she was serving, this includes using tongs to handle the bread slices. The dietary cook should not have used her gloved hands to pick up the bread slices.</p> <p>On 10/9/14 at 2:30 p.m., the Dietary Manager provided the Use of Gloves policy, dated 04/2011, and indicated the policy was the one currently being used by the facility. The policy indicated, "... 3. Gloves are just like hands; they get soiled. Anytime a contaminated surface is touched, gloves must be changed and hands washed...."</p> <p>On 10/9/14 at 2:30 p.m., the Dietary Manager provided the Food Handling Policy, dated 01/2014, and indicated the policy was the one currently being used by the facility. The policy indicated, "... 1. Food employees ... will clean their hands and exposed portions of their arms: ... d) after handling soiled surfaces, equipment or utensils;"</p> <p>2. During the service of noon meal on 10/10/14 at 11:00 a.m., the following were observed:</p>		<p>Executive Director</p> <p>·In addition, a full sanitation audit will be conducted by RD Consultant monthly</p> <p>·If 95% threshold is not achieved on the Sanitation/Environmental Review tool, an action plan will be developed to ensure compliance</p>				

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	<p>A. Dietary Aide #10 was observed to have facial hair, a beard and mustache, uncovered while preparing and serving the noon meal.</p> <p>B. Dietary Cook #1 was observed to prepare and serve the noon meal with her hair net covering only the back half of her hair, exposing the front half of her hair.</p> <p>On 10/10/14 at 1:30 p.m., review of policy provided by dietary manager as facility's current policy: American Senior Communities Dietary Personal Hygiene, original date of 02/07. "Policy: Employees will maintain good personal hygiene to prevent food contamination...Under procedure #3 a. Wear a clean hat and/or other hair restraint. Dietary employees with facial hair should also wear a beard restraint...."</p> <p>During an interview with the Dietary Manager on 10/10/14 at 1:30 p.m., she indicated the staff receive training and policies are gone over during orientation, and staff receive miniseries and protocol updates through the duration of their employment. She indicated she expects the hair cover to effectively cover head and/or facial hair (moustache and/or beard) and be worn in the food preparation areas to prevent contamination of food equipment and</p>						

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F000431 SS=E	<p>utensils.</p> <p>3.1-21(i)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug</p>						

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	<p>Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to store medications in a safe and sanitary manner in 5 of 5 medication carts reviewed for medication storage. (West Back Medication Cart #1, West Medication Cart #2, East Medication Cart A, East Medication Cart B, and Augusta's Cottage Medication Cart)</p> <p>Findings include:</p> <p>1. During a review of the West Back Medication Cart #1 on 10/15/14 at 10:45 a.m., the medication cart was found to have a build up of dust and debris in each drawer, as well as multiple loose medications. The packages of medications filled the drawers making removal and replacement of the packages difficult. The bottom drawer had a white and brown substance splashed on the sides and bottom of the drawer. Licensed Practical Nurse (LPN) #7 indicated the carts were cleaned by the night nurses according to the schedule.</p> <p>The Director of Nursing Services (DNS) and Unit Manager (UM) #6 were present</p>	F000431	<p>F431 DRUG RECORDS, LABEL/STORE DRUGS AND BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biological in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and</p>		11/03/2014		

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	<p>during the review of the medication cart. The DNS indicated the loose pills were unidentifiable, and totaled 70 whole pills, 15 capsules, and 19 and 1/2 half pills. The medications were various sizes, shapes, and colors.</p> <p>2. During a review of the West Medication Cart #2 on 10/15/14 at 11:05 a.m., the medication cart was found to have a build up of dust and debris as well as multiple loose medications. LPN #8 indicated the medications were unidentifiable and totaled 27 and 1/2 pills, 4 of which were capsules. The medications were various sizes, shapes, and colors.</p> <p>3. During a review of the East Medication Cart #A on 10/15/14 at 11:15 a.m., the medication cart had a build up of dust and debris and a dried brown substance in the bottom drawer, as well as loose medications. UM #3 indicated the medications were unidentifiable and totaled 4 and 2 1/2 pills. The medications were various sizes, shapes, and colors. UM #3 indicated the carts were cleaned by the night nurses and were reviewed on a weekly basis by the UM.</p> <p>4. During a review of East Medication Cart #B on 10/15/14 at 11:20 a.m., the</p>		<p>Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·All medication carts have been cleaned and overstocked medications have been removed <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All medication carts have been cleaned by Nurse Managers and overstocked medications have been removed ·Licensed Nurses will be in-serviced on proper medication storage by 11/3/14 ·Daily cart audits will be done by Nurse Managers to ensure carts are free from debris, organized, and no loose pills ·Licensed Nurses will wipe down carts after each shift ·Pharmacy consultant will audit medication carts monthly for proper storage 				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155241		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/15/2014	
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	<p>medication cart had 4 loose pills in the drawers. LPN #8 indicated the pills could not be identified.</p> <p>5. During a review of the Augusta's Cottage Medication Cart on 10/15/14 at 11:30 a.m., the cart had a build up of dust and debris, as well as loose medications. UM #3 indicated the medications were unidentifiable and totaled 9 and 3 1/2 pills, 3 of which were capsules. UM #3 indicated the nurses were responsible for maintaining the cleanliness of the carts.</p> <p>On 10/15/14 at 11:00 a.m., UN #6 provided a cleaning schedule for the West medication carts. The schedule indicated Cart #1 was cleaned on Tuesdays and Cart #2 was cleaned on Wednesdays.</p> <p>On 10/15/14 at 11:45 a.m., UM #3 indicated a written schedule was not available for the cleaning of the East Carts and the Augusta's Cottage Cart.</p> <p>On 10/6/14 at 11:09 a.m., the DNS provided the Medication Storage Requirements Policy dated 2/2014 and indicated the policy was currently used by the facility. The policy indicated, "Purpose To ensure drugs and biologicals are stored in a safe and secure manner in accordance to all</p>		<p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·All medication carts have been cleaned and overstocked medications have been removed ·Licensed Nurses will be in-serviced on proper medication storage by 11/3/14 ·Daily cart audits will be done by Nurse Managers to ensure carts are free from debris, organized, and no loose pills ·Licensed Nurses will wipe down carts after each shift ·Pharmacy consultant will audit medication carts monthly for proper storage <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·Medication Storage CQI tool will be utilized weekly x 4, monthly x 6, and quarterly thereafter for one year. Data will be submitted to the CQI committee for follow up. If 95% threshold is not achieved, an action plan will be developed. 				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	<p>manufacture's recommendations and State and Federal laws, rules, and regulations...3.1. Medication carts...must be of sufficient size to permit storing without undue crowding...3.2. The medication preparation area is to be maintained by nursing staff in a clean and organized manner...."</p> <p>3.1-25(m)</p>						